EXHIBIT 286

(Rev. 44, 05-08-09)

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET

Worksheet completed by the SA surveyor to gather data of worksheet, not to be given to provider to fill out.

CMS Certification Number (CCN): _____ Date of Worksheet Update: _____

Medicaid Provider Number: _____ (MMDDYYYY) (M1)

National Provider Identification Number*(s)* (NPI): _____

Fiscal Year Ending Date (MMDD): _____

Name and Address of Facility (Include City, State):

_____

_____

_____Zip Code: _____

Telephone Number (M2): _____ Fax Number (M3): _____

CEO Telephone Number: _____

Email Address: _____

Website Address: _____

Accreditation Status:_____ **Effective Date of Accreditation: _____**

Select one **(MMDDYYYY) (M4)**

0 Not Accredited

1 JC **Renewal Date of Accreditation:_____**

2 AOA **(MMDDYYYY) (M5)**

3 DNV

Multiple Accreditation Status: Yes_____ No_____

(Select all others that apply; do <u>not</u> include the primary accreditation organization):

JC _____

AOA_____

DNV_____

State/County Code (M6):_____ **State Region Code (M7):_____**

Type of Program Participation (M8):_____

Select one

1 Medicare

2 Medicaid

3 *Medicare & Medicaid*

CLIA ID Numbers (M9):

_____

_____

_____

_____

_____

Medicare CAH Status or Type of Medicare Hospital **(select 1) (M10):_____**

01 Short-term ___

02 Long-term ___

03 Religious Nonmedical Health Care Institution___

04 Psychiatric ___

05 Rehabilitation ___

06 Childrens___

07 Distinct Part Psychiatric Hospital__

08 Cancer Hospital___

11 Critical Access Hospital (CAH)___

Affiliation with a Medical School (M11):_____

01 Major **02 Limited** **03 Graduate School** **04 No Affiliation**

Resident Programs (M12) (select all that apply):_____

01 *Allopathic* **02 *Dental*** **03 *Osteopathic*** **04 Other** **06 Podiatric**

Ownership Type (select 1) (M13):_____

01 Church

02 Private (Not for Profit)

03 Other (specify:_____

04 *Private* (For Profit)

05 Federal_

06 State

07 Local

08 Hospital District or Authority

09 Physician Ownership

10 Tribal

Average Daily Census (M14):_____

Number of Staffed Beds (M15):_____

Type of Chain/Health System Involvement (M16):_____

01 None
02 System Ownership
03 System Management

Name of System (M17):_____

Corporate Headquarters City (M18):_____ State (M19):_____

Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalents FTE)					
M20	**Physicians (Salaried only)**		**M30**	**Medical Technologists (Lab)**	
M21	**Physicians - Residents**		**M31**	**Nuclear Medicine Technicians**	
M22	**Physician Assistants (PA)**		**M32**	**Occupational Therapists**	
M23	**Nurses - CRNA**		**M33**	**Pharmacists (Registered)**	
M24	**Nurses - Practitioners**		**M34**	**Physical Therapists**	
M25	**Nurses - Registered**		**M35**	**Psychologists**	
M26	**Nurses – LPN**		**M36**	**Radiology Technicians (Diagnostic)**	
M27	**Dieticians**		**M37**	**Respiratory Therapists**	
M28	**Medical Social Workers**		**M38**	**Speech Therapists**	
M29	**Medical Laboratory Technicians**		**M39**	**All Others**	

Medicare Payment-Related Categories for **a Hospital or a CAH (select all that apply) (M40):_____**

	CAH Categories			Hospital Categories	
01	**CAH Psychiatric DPU**		**07**	**Hospital PPS Excluded Psych Unit**	
02	**CAH Rehabilitation DPU**		**08**	**Hospital PPS Excluded Rehab Unit**	
03	**CAH Swing Beds**		**09**	**Hospital Swing Beds**	
			10	**Medicare Dependent Hospital**	
			11	**Regional Referral Center**	
			12	**Sole Community Hospital**	

Services Provided by the Facility (M41):_____

0 Service not provided

1 Services provided by facility staff only

2 Services provided by arrangement or agreement

3 Services provided through a combination of facility staff and through agreement

			34	Operating Rooms	
02	Alcohol and/or Drug Services		35	Opthalmic Surgery	
03	Anesthesia Service		36	Optometric Services	
04	Audiology				
			38	Organ Transplant Services *(Not Medicare-certified)*	
06	Burn Care Unit		39	Orthopedic Surgery	
07	Cardiac Catheterization Laboratory		40	Outpatient Services	
08	Cardiac-Thoracic Surgery		41	Pediatric Services	
09	Chemotherapy Service		42	Pharmacy	
10	Chiropractice Service		43	Physical Therapy Services	
11	CT Scanner		44	Positron Emission Tomography Scan	
12	Dental Service		45	Post-Operative Recovery Rooms	
13	Dietetic Service		46	Psychiatric Services - Emergency	
14	Emergency Department (Dedicated)		47	Psychiatric - Child/Adolescent	
			48	Psychiatric - Forensic	
16	Extracorporeal Shock Wave Lithotripter		49	Psychiatric - Geriatric	
17	Gerontological Specialty Services		50	Psychiatric – Adult Inpatient	
			51	Psychiatric - Outpatient	
			52	Radiology Services - Diagnostic	
20	ICU - Cardiac (non-surgical)		53	Radiology Services - Therapeutic	
21	ICU - Medical/Surgical		54	Reconstructive Surgery	
22	ICU - Neonatal		55	Respiratory Care Services	
23	ICU - Pediatric		56	Rehab Services - Inpatient	
24	ICU - Surgical				
			58	Rehab -Outpatient	
26	Laboratory - Clinical		59	Renal Dialysis (Acute Inpatient)	
			60	Social Services	
28	Magnetic Resonance Imagining (MRI)		61	Speech Pathology Services	
29	Neonatal Nursery		62	Surgical Services - Inpatient	
30	Neurosurgical Services		63	Surgical Services - Outpatient	
31	Nuclear Medicine Services		64	Trauma Center *(Designated)*	
32	Obstetric Service		*65*	*Transplant Center (Medicare Certified)*	
33	Occupational Therapy Services		66	Urgent Care Center Services	

Sprinkler Status, *Main Campus* (select 1) (M42): _____

01 Totally sprinklered: All required areas are sprinklered

02 Partially sprinklered: Some but not all required areas are sprinklered

03 Sprinklers: *No required areas are sprinklered*

Total number of *provider-based* off-site locations under the same CCN (M43):_____

TYPES OF OFF-SITE LOCATIONS					
01	**Inpatient Remote Location**		**07**	**Satellite of a*n I*PPS-Excluded Psych Unit**	
02	**Offsite Outpatient Surgery**		**08**	**Satellite of a Long Term Care Hospital**	
03	***Offsite* Urgent Care Center**		**09**	**Satellite of a Cancer Hospital**	
04	**Satellite of a Rehabilitation Hospital**		**10**	**Satellite of a Childrens' Hospital**	
05	**Satellite of a Psychiatric Hospital**		**1*1***	***Offsite* Emergency Department**	
06	**Satellite of a*n I*PPS-Excluded Rehab Unit**		**1*2***	**Other Provider-Based Offsite Facility*/Department***	

***For each* off-site location, complete and attach the Provider-Based Off-Site Locations Continuation Worksheet.**

Number of related or affiliated providers or suppliers (M*44*):_____

TYPES OF AFFILIATED PROVIDERS*/SUPPLIERS*					
01	***Ambulance Service***		**0*6***	**Hospice**	
0*2*	**Ambulatory Surgery Center**		**07**	***Organ Procurement Organization***	
0*3*	**End Stage Renal Disease**		**08**	**Psychiatric Residential Treatment Facility**	
0*4*	**Federal*ly* Qualified Health Center**		**09**	**Rural Health Clinic**	
0*5*	**Home Health Agency**		**10**	**Skilled Nursing Facility (SNF)**	

For each affiliated provider/supplier, complete and attach the Affiliated Provider/Supplier Continuation Worksheet, indicating the provider/supplier name, CCN, and type.

(M45) Co-location Status: Is there another hospital, or a satellite location of another hospital, that occupies space in a building used by the hospital described in this worksheet?

01 Yes
02 No

If yes, provide the name and CCN number of the co-located hospital:

Name_____ CCN_____

PROVIDER-BASED OFF-SITE LOCATION CONTINUATION WORKSHEET
PAGE 1 OF _____

ENTRY# _____
***Type of* Off-site Location (from table M43): _____**
Name of Off-Site Location: _____
Off-Site Street Address: _____
County: _____
City: _____State:_____ Zip Code:_____
Sprinklered Status of Off-site Location (select 1): _____

- **01 Totally sprinklered: All required areas are sprinklered;**
- **02 Partially sprinklered: Some but not all required areas sprinklered;**
- **03 Sprinklers: *No required areas are sprinklered***
- **04 Sprinklers are not required**

ENTRY# _____
***Type of* Off-site Location (from table M43): _____**
Name of Off-Site Location:_____
Off-Site Street Address: _____
County: _____
City: _____State:_____ Zip Code:_____
Sprinklered Status of Off-site Location (select 1): _____

- **01 Totally sprinklered: All required areas are sprinklered;**
- **02 Partially sprinklered: Some but not all required areas sprinklered;**
- **03 Sprinklers: *No required areas are sprinklered***
- **04 Sprinklers are not required**

ENTRY# _____
***Type of* Off-site Location (from table M43): _____**
Name of Off-Site Location:_____
Off-Site Street Address: _____
County: _____
City: _____State:_____ Zip Code:_____
Sprinklered Status of Off-site Location (select 1): _____

- **01 Totally sprinklered: All required areas are sprinklered;**
- **02 Partially sprinklered: Some but not all required areas sprinklered;**
- **03 Sprinklers: *No required areas are sprinklered***
- **04 Sprinklers are not required**

Make additional copies as needed for additional off-site locations.

AFFILIATED *PROVIDER/SUPPLIER* CONTINUATION WORKSHEET PAGE 1 OF_____

Identify all affiliated Medicare-*certified* providers/suppliers*, indicating for each the name, CCN, and type of provider/supplier, using the codes from M44.*

Entry #_____

Name_____ CCN_____

Type of Provider/Supplier _____

Entry #_____

Name_____ CCN_____

Type of Provider/Supplier _____

Entry #_____

Name_____ CCN_____

Type of Provider/Supplier _____

Entry #_____

Name_____ CCN_____

Type of Provider/Supplier _____

Entry #_____

Name_____ CCN_____

Type of Provider/Supplier _____

Make additional copies as needed for additional affiliated provider*s/suppliers*.